DELTA DENTAL

Delta Dental Plan of Massachusetts

MCOFU HEALTH AND WELFARE PLAN

DENTAL/VISION ENROLLMENT FORM & PAYROLL DEDUCTION AUTHORIZATION

FAX: 603-647-4668

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MCOFU Administrator Mailing Address:

Benefit Strategies, LLC, PO Box 3938, Manchester, NH 03105-3938

Group Name: MCOFU	Effective Date:	Date of Hire:	Telephone #:	Dental Plan (Check one): Delta Dental PPO / Plus Premier	Employer: (Check one): ___ Comm. Of MA ___ Bristol County ___ Dukes County ___ Plymouth County
Social Security Number:	Last Name (Subscriber):			First Name:	DOB: / Sex:
Home Address:				City:	State: / Zip Code:

List All LEGAL Dependents Covered Under Your Plan:

Only your LEGAL dependents are eligible. Please be prepared to provide proof of legal dependent status if asked, especially if your dependent(s) have a different last name from you.

If any covered dependents are over the age of 19, you must provide documentation that they are Full-Time Students each year.

First Name	Last Name (if different from subscriber)	Date of Birth	Sex (M, F)	Check if dependent is over 19 and a Full Time Student
Subscriber				
Spouse				
Children				

Reason For Submission (Check One)

- ☐ **New Enrollment:**
  - ☐ Single Coverage
  - ☐ Family Coverage
- ☐ **Coverage Level Change:**
  - ☐ Single to Family
  - ☐ Family to Single
- ☐ **Terminate Coverage:**

Date of Termination: _____

- ☐ **Name/Address Change**
- ☐ **Add Dependent(s) to Plan: Name(s)** _____
- ☐ **Remove Dependent from Student Status: Name** _____
- ☐ **Add Dependent to Student Status: Name** _____
- ☐ **Transfer to COBRA Status**

Vision Plan Selected: (Check One)

☐ **EyeMed Vision Plan** ☐ **Correctional Industries Voucher Plan**

Please Read and Sign Below:

- I hereby certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my Employer or Plan Sponsor, in accordance with the underwriting guidelines of Delta Dental Plan of Massachusetts.
- I hereby authorize my Employer to deduct from my pay $3.00/week for Single Coverage or $6.00/week for Family Coverage as selected above for my participation in the MCO Health and Welfare Fund's Dental/Vision benefit plans. (Dukes County Employee contribution is $16.17 per week for Single coverage, and $17.78 per week for Family coverage.)

Employee Signature: **Date:**

Administrator Authorization: **Date:** **Payroll Deduction: $**